

**HOW WE HELP OUR PATIENTS:  
THE DIVERGENCE BETWEEN PRIVATE VIEWS  
AND PUBLIC THEORIES**

*Commencement Address*

*U.C.S.F. Psychiatry Department*

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I'm honored and delighted to have been invited to speak this year at your commencement ceremonies. So I thank you. This is a great event. As I looked at the long list of those of you who will be receiving diplomas and awards today, I was really struck by how many areas of expertise you represent...and by how many levels and kinds of training you've achieved -- residencies, pre-doctoral fellowships, post-doctoral fellowships, Ph.D.'s...with specialties in psychopharmacology, the molecular basis of psychiatry, child work, adolescent work, inpatient work, drug abuse treatment, molecular genetics, clinical services as well as basic sciences research, and on and on: you know the list a lot better than I do. It's quite a department that manages to contain all of you under one roof. Then again, it's quite a field, this field of psychiatry at the end of the 1990's, with many faces, many apparently mutually contradictory self-definitions and mutually exclusive trajectories for the future.

So I was a little fazed as I wondered what I might talk to you about today -- all of you, in one room, at one single commencement ceremony. What do you have in common? How does the territory that you experts in biological psychiatry have staked out -- how does that territory interface with the territory occupied by you behavioral therapists? Or -- perhaps worse -- you psychoanalytic candidates? Or you behavioral neurologists, or you psychoneuroimmunologists, or you specialists in addiction or family systems work? How do any of us relate to each other? What can we really claim in common, as we carve out our tenuously boundaried enclaves in what we're currently calling psychiatry?

The nice thing about a basic question like that is how it does bring you back to basics. And after all, the basic thing each one of us is after is pretty simple -- we're out to help people. Specifically, we're out to help them based on a notion that there's a way into psychic experience that we can access -- there's a way into the mind, and into people's subjective experience of life, that's fundamentally approachable by us and malleable, capable of alteration. That's true whether we're prescribing drugs or hypnotizing people or doing psychoanalysis or developing protocols for behavior modification. So we've got that in common.

It gets trickier with the next step, when we start specifying how it is that whatever we're doing with people is helping them. At our best, I believe, we try to address

that question by operating at a very elementary empirical level. We observe that something we do helps someone, so we entertain the hypothesis that whatever that something was, it might be something that constitutes a useful tool for our work and it might be something we'd want to do again. We might even build an entire career around doing whatever that something happened to be.

Now that, as I say, is us at our best. It's us at our best because, on the one hand, it's essentially honest, and, on the other, it's essentially humble. It's us operating out of the correlative kind of reasoning we do all the time in daily life, and that we've been doing ever since each of us was a few months old. When we do A, B seems to happen, so if we want B to happen, we'll do A again. Not a particularly sophisticated logic, but one that's tried and true, reliable under lots of circumstances.

So if that's who we are at our best, who are we at our worst? Well -- I think at our worst we're not satisfied with what I called the elementary empiricism of the logic I just described, nor with the level of theorizing which that level of empiricism permits. Instead of being satisfied with the observation that when we do A, B seems to happen, we start to think: Ah-hah...now we know A makes B happen, or now we know that B only happens when we do A, or now we know that A is the only way to get B to happen. And of course, that logic quickly turns into the claim that A is the new magic bullet or the basis on which managed care can really work in psychiatry or the first premise of a new school of psychiatric thought, and then there we are, fighting battles about what really works in psychiatry. But we're not fighting about what really works. We're fighting battles based on misguided logical developments of the kind I just described: battles which confuse correlation with causality, observation with inference, and subjectivity with objectivity. We've removed ourselves from anything resembling elementary empiricism, and we find we're engaged in turf battles over personal preferences elevated to the status of theory, turf battles that amount to religious warfare. That's us at our worst.

So how do we get there -- to us at our worst? And how is it that we keep getting there? And how can you, as you go off to establish your various individual careers in psychiatry and psychology, how can you keep yourselves from getting there?

I ask you this because it seems to me that it's one way of articulating the really central challenge which you'll each be facing as you matriculate into our peculiar field of psychiatry at this particular moment in its development. The challenge you're facing is not just that you're entering a peculiar field -- though you are, and I'll say more about that in a moment. The real challenge for you lies in the fact that you're entering a field which suffers from a truly malignant case of defensiveness about its own peculiarity. And that, I think, is significantly responsible for how we turn into us at our worst and it therefore delineates the challenge you'll each be facing as you try to avoid joining us at our worst.

So now back to what's peculiar about us. I think we're peculiar largely because of the extraordinary complexity of what we set out to do and how we set out to do it. We attempt to deal with people in the full complexity of their existence as simultaneously biological, emotional, social, cognitive, and even spiritual beings. Not content with all that complexity, we set out to deal with people in the explicit and intentional

context of the most complex crucible in the world -- the context of regularly and purposefully forged human relationships between ourselves and each of our patients.

The enormity of all that has its impact. It makes us different from a lot of our professional peers who have the luxury of finding that their work is furthered by toning down complexity, by simplifying or compartmentalizing or dichotomizing. Our work isn't like that. We have to live with complexity in a way that requires a peculiar defiance not only of ubiquitous human tendencies toward the comfortable, but also a peculiar defiance of the way our professional culture happens to institutionalize its reward system -- most notably perhaps (dare I say it), the way great medical settings like this one hierarchically rank-order the pay-offs that accompany various approaches to solving human problems. Compartmentalizing tends to come out ahead.

So that speaks to how we're peculiar. And while it's never easy to be peculiar, we still need to answer the question of why we have to be as defensive about it as it seems to me we are. My own guess is that our defensiveness has something to do with ways in which all the complexity I just described introduces lots into what we do which doesn't integrate very comfortably into what we're used to calling science, lots that we can't recognize as the variables which fit smoothly into our familiar scientific paradigms. As a result, I think we're tempted, whenever we see the chance, to do certain things that end up being troubling. We turn the multi-variate into the single-variate, we elevate correlation into causality, we confuse observation with inference and we reduce the quintessentially subjective into something that looks a little more like what we call objective. It's in that process, I believe, that we turn ourselves into us at our worst. Unhappily, it's also in that process that we come up with most of our theories about what works in psychiatry.

Now there's a very real irony here. In our need to make psychiatry look like science, we abandon the central premise that makes real science possible: the premise that says elementary empiricism is really all that counts. That's what makes for science, even if it leaves us very far removed from the grand and overarching theory-building which might make us feel more secure that we know why we do what we do in a scientific-sounding way.

So I'm suggesting that we -- as of today, you -- put your efforts into sticking with elementary empiricism. By that I don't mean the empiricism of quantitative measures or statistics or even the empiricism of what we're accustomed to calling empirical research. I mean: stick with your own experience. Stick with it in its most elementary form. Stick with: when A happens, B seems to happen, and stick with specifying nothing more than all the myriad details of that conjunction as you observe your own intensely personal experience of it.

Now that sounds pretty simple and pretty plodding in its aspiration. But actually, I think it's neither. The kind of experience-near empiricism I'm talking about takes not only rigorous honesty, but also terrific humility. In addition it takes -- and here's the paradox, and maybe the hardest part -- it takes acknowledging certain private, inchoate ways in which you probably know not less but a lot more than you've actually let on that you know -- to your teachers, your peers, or even yourselves.

Let me give you an example. I'm sure all of you have at least once had the

heady experience of doing whatever A you happen to specialize in -- giving out Prozac, say, or psychoanalytic interpretations -- and discovering that the B which followed far exceeded your wildest anticipations. It is a heady experience. You did your particular version of A, and the B that ensued was terrific. You really helped someone.

Now: what do you do with that experience? How do you incorporate it? Do you take it as evidence that your theories about A must just be better than you'd ever imagined? Do you sequester the experience from your daily work by classing it as an odd but gratifying anomaly? Or do you -- and this gets to the stance of elementary empiricism I've been talking about -- do you consider that if you really look closely enough at what happened, you may start to identify evidence that you were operating out of something in yourself that might constitute knowledge and important knowledge -- knowledge that's too confusing, too uncertain and too embryonic to articulate fully to yourself, much less your supervisors?

I'm suggesting that the elementary empiricism which turns us into us at our best involves exploring that last alternative. The key thing to me (and the reason why psychiatry remains an incredibly exciting field), the key thing strikes me as this: at our best, we actually do manage to help people. But I don't think we know much -- yet -- about how we do it. That is, I believe our public theories about how we help people tend to emerge from a different level of our collective functioning than does our best clinical work, whether we're dealing in psychopharmacology or psychodynamics. The result is that our public theories about what we do and why we do it are often quite removed from how, privately, we come to feel we actually help our patients. To the extent that our theories emerge from us at our worst -- from us at what I described as our most malignantly defensive -- we come up with theories that do all the anti-scientific things I talked about earlier: they turn the multi-variate into the single-variate and correlation into causality; they confuse inference with observation and subjectivity with objectivity. And the insidious temptation as you try to establish a place in our field is to disavow personal, uncertain, experience-near knowing for the sake of the knowing which is proclaimed by our theories, the consensual, publicly authorized knowing that has already achieved the status of theory. The temptation is to accede to the idea that the best defense against uncertainty is someone else's certainty, the best defense against peculiarity is joining a crowd. And there we have the prescription for how we give up being us at our best.

And women: for all kinds of fascinating and complicated and as-yet ill-understood reasons, I think the temptation to sacrifice that personal, experience-near knowing is especially and insistently insidious for you. So I address you particularly when I say: if you find yourselves at odds with public theories about how you're supposed to be feeling and functioning, don't give in. Distinguish yourselves by being ultimately and stubbornly scientific in the truest sense, ultimately and stubbornly determined to stick with your own knowing -- the singular, idiosyncratic, inwardly lively knowing that will make you ultimate empiricists, but ultimate humanists as well. Your particular knowing may not sound exactly like the science we've come to recognize as familiar. That's precisely why it has the potential to galvanize, expand and advance our field.

So I wish every one of you great congratulations and good speed as you step out into our quintessentially peculiar, quintessentially challenging, but consumately rewarding field of psychiatry. Join us at our best and we'll see great things coming.